

Arthritis Action Plan

For Washington State: 2001–2005

May 2001



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Executive summary

The purpose of this action plan is to propose a public-health approach to arthritis prevention and management.

Background: The national picture

In the United States, arthritis is the cause of at least 44 million visits to health-care providers, almost 750,000 hospitalizations and four million days of hospital care each year.

Health effects of arthritis in Washington

The Centers for Disease Control and Prevention estimate that by 2010, over one million people in Washington State will have symptoms of arthritis. In a 2000 survey conducted in Washington, 23 percent of adults responding said they had been told by a doctor that they had arthritis, and 26 percent said they experienced joint pain for one month or longer. Of those reporting a diagnosis of arthritis, 35 percent said they had osteoarthritis or degenerative arthritis.

The CDC estimates that, by the year 2010, well over one million people in Washington State will have symptoms of arthritis.¹

Who is at risk and what can be done

While some of the factors that contribute to a greater risk of developing arthritis cannot be modified (such as gender, age and genetic predisposition), several risk factors can be. Safe work practices, weight management and physical activity can all reduce the risk of developing arthritis. Early diagnosis can also prevent, or at least minimize, discomfort and disability caused by arthritis.

Efforts to address arthritis

While there are a number of methods available to manage or even avoid the symptoms of arthritis, many people tend to accept arthritis as an inevitable part of aging. As a result, they do not avail themselves of information and treatments that could alleviate their symptoms or even forestall the onset of the disease. Moreover, there are promising new treatments that need to be brought to the attention of health-care providers, caregivers and people with arthritis.

A large portion of our aging population in Washington could benefit from increased information regarding arthritis and its treatments. Additionally, health-care providers can be more effective in addressing the effects of arthritis on their patients by having improved access to information and new treatment options.

The Arthritis Action Plan for Washington State

The action plan defines the nature of the disease, identifies who is at risk and addresses why a public-health approach to arthritis prevention and management is appropriate. The plan addresses three areas of action:

Surveillance and epidemiology;

Communication and education; and

Programs, policies and systems.

Each is accompanied by key objectives and activities designed to meet the goals of the plan.

Surveillance and epidemiology

Objective 1: Continue to use the Behavioral Risk Factor Surveillance System (BRFSS), Comprehensive Hospital Abstract Reporting System (CHARS), and other data systems and information to monitor the quality of life for Washington residents with arthritis.

Objective 2: Disseminate surveillance findings to policy makers, public and private organizations, and health care professionals to increase knowledge of the scope of the disease and its implications for health care policy.

Objective 3: Build capacity to disseminate the most effective interventions that have the greatest overall impact on the population.

Communication and education

Objective 1: Identify three program areas to link arthritis messages with other chronic disease prevention messages.

Objective 2: Promote partnerships to deliver consistent messages.

Objective 3: Develop strategies to inform people with arthritis of existing programs and services available to help them.

Objective 4: Promote the value of early diagnosis and appropriate management to health care providers and people with arthritis.

Objective 5: Improve access to information on assistive technology that is feasible and relates to people with arthritis.

Programs, policies and systems

Objective 1: Identify strategies to modify health care systems to improve clinical services.

Objective 2: Build arthritis capacity into the public health infrastructure.

Objective 3: Develop strategies to improve statewide access and culturally-appropriate services.

Objective 4: Use and disseminate evidence-based disease management programs and approaches.

Objective 5: Further strengthen the partnership between the Arthritis Foundation Washington/Alaska Chapter and the Washington State Department of Health.

Arthritis: includes more than 100 diseases and conditions affecting joints, the surrounding tissues, and other connective tissues. Osteoarthritis (OA) and rheumatoid arthritis (RA), the two most common forms of arthritis, have the greatest public health implications.

Osteoarthritis: a degenerative bone disease characterized by the breakdown of joint cartilage. It is the most common form of arthritis and affects middle-aged and older people. Osteoarthritis is not a normal part of aging, but factors such as obesity, sports or work related activities and injuries may increase a person's risk of developing osteoarthritis.

Rheumatoid Arthritis: a systemic disease that affects the entire body. It is characterized by inflammation of the membrane of the joint lining. Bone and cartilage are damaged resulting in pain and loss of movement. This disease usually begins in middle age and affects two to three times more women than men.

Arthritis and other rheumatic conditions are the leading cause of disability in the United States.

For more information regarding the development or implementation of this action plan, please contact Ruth Abad, Washington State Department of Health, Office of Health Promotion, P.O. Box 47833, Olympia, Washington 98504-7833; E-mail: ruth.abad@doh.wa.gov.

Plan development

Many organizations came together to create the *Arthritis Action Plan for Washington State*, including the Arthritis Foundation Washington/Alaska Chapter, the Washington State Department of Health, and a diverse committee of representatives from public health, health care, aging and adult service providers and consumers. A grant from the U.S. Centers for Disease Control and Prevention (CDC) made the project possible.

The 20-member advisory group met during 2000 to review the *National Arthritis Action Plan: A Public Health Strategy* and to develop goals, objectives, and activities specific to Washington State.

In developing the plan, the advisory group used information gathered from focus groups and key-informant interviews conducted in September 2000. Four focus groups (composed of men and women age 50 or over with symptoms of arthritis) provided valuable insights on what types of communication and community services would encourage people with symptoms of arthritis to seek a formal diagnosis and manage their disease more effectively.

In addition, 15 primary care providers and pharmacists were interviewed to better understand their knowledge of the latest recommendations on arthritis treatment and management, and community-based services available to help people with arthritis manage their disease.

The advisory group also reviewed preliminary data gathered from persons with arthritis through a behavioral risk factor telephone survey conducted by the Department of Health Disability Prevention Program during 2000.

During the same period, the Arthritis Foundation Washington/Alaska Chapter developed a five-year strategic plan, building upon the objectives and strategies generated during development of the *Arthritis Action Plan for Washington State*. These include objectives that address communication, education, building partnerships, and identifying additional resources to carry out activities described in this plan.

Focus Group and Key-Informant

Research: Four focus groups of consumers and 15 key informant interviews with health care providers were conducted during September 2000 to provide input for developing the *Arthritis Action Plan for Washington State*.

The focus groups were made up of men and women age 50–64 and 65–80 who reported symptoms of arthritis for more than a month. Half of the participants had not seen a physician for a formal diagnosis. The purpose was to help decide what community services and communications should be included in the state plan to support and influence people with symptoms of arthritis to do each of the following recommendations:

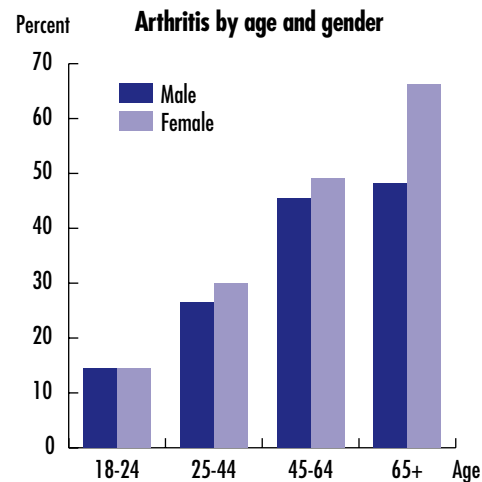
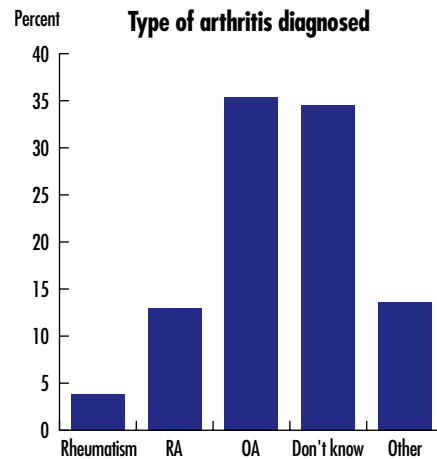
1. See a doctor for formal diagnosis;
2. Get advice from a physician on managing the disease;
3. Seek out more information on what does and doesn't help;
4. Manage arthritis through appropriate physical activity, weight management and appropriate medication.

The burden of arthritis in Washington State

Arthritis is typically defined as having joint pain and swelling most days for longer than one month (a medical diagnosis may be necessary to confirm the presence of arthritis when symptoms are not typical). There are over 100 forms of arthritis that affect more than 15 percent of people living in the United States—over 43 million persons. More than 20 percent of adults in this country suffer from arthritis, making arthritis one of the most common medical conditions in the United States.²

In a survey conducted in Washington State in 2000:

- 40 percent of adults sampled said they had some form of arthritis.³
- Of those diagnosed with arthritis, 35 percent had osteoarthritis or degenerative arthritis.
- 23 percent of people in the sample said a doctor had told them that they had arthritis.
- 26 percent said they experienced joint pain for one month or longer.
- Two percent of those who reported having been diagnosed with arthritis said they were told they had more than one type.
- Arthritis in Washington State is more prevalent among women than among men. The rate for women is 43 percent; among men it is 36 percent. At younger ages, men and women have equal rates of arthritis, but by age 45, women's rates are higher.
- Age is a strong factor in the development of arthritis; 36 percent of adults sampled under the age of 65, and 59 percent of those over 65, reported having arthritis.



Public health impact

Arthritis affects nearly every aspect of a person's life. People with arthritis:

- Are more likely to need daily assistance in self-care activities;
- Are less likely to be employed, more likely to be retired, and more likely to say they are unable to work (even among those who are not of a typical age to retire);
- Tend to have lower incomes;
- Are more likely to report poor health; and
- Are more likely to report health-related limitation in their daily activities.

The public health impact of arthritis is significant. Arthritis is the leading cause of disability.⁴ It limits the major life activities (such as working, school, and housekeeping) of one out of five people with arthritis, limiting their independence and disrupting the lives of family members and other caregivers.

Arthritis also has a sizable economic impact. Nationally, arthritis is the source of at least 44 million visits to health care providers, 744,000 hospitalizations, and four million days of hospital care per year.⁵

Who is at risk

Certain factors contribute to a greater risk of developing arthritis. These include non-modifiable factors, such as being **female, over age 65, and/or having a genetic predisposition**. Although these factors cannot be changed, knowledge of their presence helps identify groups at higher risk for arthritis.

Some risk factors, however, can be modified or avoided through behavior modification. Preventable or modifiable risk factors associated with increased risk of arthritis include **obesity, joint injuries, Lyme disease and certain occupations** such as shipyard work, farming, heavy industry, and occupations with repetitive knee bending.

Why arthritis is a concern for public health

Despite the common myth that arthritis is an inevitable part of growing older, effective interventions are available to delay or prevent disability from arthritis or at least minimize its complications. Some forms of arthritis, such as osteoarthritis, can be prevented with weight control, appropriate physical activity, and avoidance of certain sports and occupational injuries.

Early diagnosis and appropriate management can minimize the pain and disability that people with arthritis experience. This also includes weight control and appropriate physical activity, as well as self-management of symptoms, medications, physical and occupational therapy, and joint replacement therapy when indicated.⁶

Taking a public health approach to arthritis suggests the following strategies:

Primary prevention is designed to prevent arthritis from occurring in the first place. Some promising strategies include: weight control, occupational injury prevention, sports injury prevention, and Lyme disease control. However, little is known about the effectiveness of primary prevention strategies as applied to broad population-based programming.

Secondary prevention promotes identification of arthritis in its earliest stages so prompt and appropriate management can begin. Early diagnosis and appropriate medical treatment, such as medications, can reduce the impact of arthritis. Much progress has been made in the areas of medication and self-help strategies, making secondary prevention an effective avenue for public health programs.

Tertiary prevention focuses on reducing or minimizing the effects of arthritis once it has progressed. These strategies can reduce pain and disability, increase a person's sense of control, and improve the quality of life. These strategies include:

1. Self-management, such as weight control and physical activity;
2. Education, such as arthritis self help courses; and
3. Rehabilitation services (such as joint replacement) that remediate impairments and improve mobility and functioning.

In contrast with the classic medical approach which addresses the individual patient, the challenge for public health is to identify and help implement strategies for improving the health of an entire population.

The **long-term goal** of taking a public health approach to arthritis is to improve the quality of life for Washington residents who suffer from its effects. The **short-term goals** of taking such an approach include:

1. Monitoring the burden of arthritis in Washington State;
2. Increasing the public's awareness of arthritis, its economic impact, and the impact on the quality of life of people with arthritis; and
3. Implementing effective programs, policies and system changes to improve the quality of life for persons with arthritis and their families in Washington State by increasing:
 - Early diagnosis and appropriate management among people with arthritis;
 - The percentage of people with arthritis who actively manage their disease, and
 - Families' ability to support persons with arthritis.

Public health approaches

The following recommendations have been developed for taking a public-health approach to addressing the effects of arthritis.

Several activities, specifically in the area of surveillance, are currently taking place. The remaining recommendations in this plan are contingent upon the receipt of additional funding to Washington State for the purpose of addressing arthritis and its complications.

Surveillance and epidemiology

Rationale: *Surveillance and epidemiology are the scientific tools of public health. They are used to obtain accurate and reliable data, identify knowledge gaps and effective ways to address them, and make provisions for disseminating data to appropriate people.*

Surveillance of arthritis is crucial for understanding the epidemiology of arthritis, targeting interventions, and developing policy. Arthritis surveillance through data systems such as the Behavioral Risk Factor Surveillance System (BRFSS) helps us understand who is affected; who is at the greatest risk; what health beliefs and behaviors increase that risk; and how arthritis affects physical health, quality of life and economics.

Surveillance, epidemiology, and prevention research are the scientific tools of public health.

The analysis of the data described in the *Arthritis Action Plan for Washington State* will be used to:

1. Set public health priorities;
2. Focus the use of limited public health resources in the most effective way;
3. Monitor changes over time that help to evaluate the effectiveness of the chosen interventions.⁷

Objective 1: *Continue to use BRFSS, Comprehensive Hospital Abstract Reporting System (CHARS) and other data systems and information to monitor the quality of life for Washington residents with arthritis.*

Activities:

1. Monitor changes in the occurrence of arthritis and its impact;
2. Collect and analyze BRFSS data on correlations between arthritis and weight and physical activity levels;
3. Analyze data on correlations between arthritis and quality of life;
4. Identify disparities in quality of life related to arthritis in different populations;
5. Identify disparities in the diagnosis and treatment of arthritis (such as joint replacement) in different populations.

Objective 2: *Disseminate surveillance findings to policy makers, public and private organizations, and health care professionals to increase knowledge of the scope of the disease and its implications for health care policy.*

Activities:

1. Include a chapter on arthritis in *The Health of Washington State: A Statewide Assessment of Health Status, Health Risks, and Health Systems*. This is the Department of Health's principle health assessment document and will increase the visibility of arthritis as a major public health problem;
2. Develop and disseminate fact sheets summarizing data findings (example: show the demonstrated relationship between the incidence of arthritis, weight and level of physical activity);
3. Present data findings at medical and public health conferences;
4. Publish data findings on the Department of Health and the Arthritis Foundation Washington/Alaska Chapter websites.

Objective 3: *Build capacity to disseminate the most effective interventions that have the greatest overall impact on population.*

Activities:

1. Review evaluations of existing interventions to find out what works for different populations;
2. Promote and support proven intervention strategies such as the National Arthritis Foundation's Self-Help Course.⁸

Communication and education

Rationale: *Health communications and health education are methods used to raise awareness of the impact of arthritis and to familiarize health professionals, care givers and persons with arthritis with effective strategies to manage and improve the quality of life of persons with arthritis. Communication and education efforts must address the twin myths that arthritis is a natural part of aging and that little can be done to alleviate the symptoms.*

The healthcare system has not yet recognized the crucial role patients have in their own self-management.

— Halsted R. Holman, MD
National Arthritis Action Plan

Proper (formal) diagnosis and management of the disease can reduce the pain from arthritis, improve mobility, and delay or prevent further complications of the disease. Adults over the age of 50 with symptoms of arthritis who participated in focus groups in Washington in 2000, confirmed the perception that old age is the cause of arthritis and “there isn’t anything you can do about it.” Consistent and well-crafted messages, based on research about audiences’ attitudes, interests, and beliefs, will increase awareness of the impact of arthritis and the importance of early diagnosis and appropriate management. Principles for communicating about arthritis will include the following:

- Assure that education and communication messages are culturally appropriate, as determined by ethnicity, race, socio-economics, gender, and educational level;
- Link with other chronic disease prevention messages such as the importance of early diagnosis, and the benefits of appropriate physical activity;
- Use a social marketing approach to develop and disseminate effective messages and programs;
- Choose educational strategies that are proven to be effective or promising;
- Use consistent messages that reinforce the value of early diagnosis and treatment, including self-management.

Objective 1: Identify three program areas to link arthritis messages with other chronic disease prevention messages.

Activities:

1. Link with current efforts to promote the benefits of physical activity and reduce obesity, pointing out their positive effects on arthritis symptoms;
2. Coordinate with the Breast & Cervical Health Program to deliver arthritis management messages to women 45 and older;
3. Coordinate educational messages with fall-prevention messages delivered by community-based programs, including Area Agencies on Aging, local health jurisdictions, emergency medical services, senior centers and hospitals;
4. Link to community-based nutrition programs for adults, including congregate meal sites, in-home care giver programs, osteoporosis prevention, and senior nutrition programs.

Objective 2: Promote partnerships to deliver consistent messages.

Activities:

1. Identify partners with the resources and commitment to implement pieces of the state plan such as the Arthritis Foundation Washington/Alaska Chapter, Group Health Cooperative, the University of Washington Program for Educational Transformation through Technology, and Washington Assistive Technology Alliance;
2. Carry out activities under Objective 1 of this section that involve state and community-based chronic disease prevention programs;
3. Identify and work with not-for-profit organizations, health care providers, pharmacists and managed-care organizations to promote consistent messages;

4. Continue to coordinate with the Arthritis Foundation Washington/Alaska Chapter to develop effective messages for use by health care providers, pharmacists, and service programs such as the YMCA.

Objective 3: *Develop strategies to inform people with arthritis of existing programs and services to help them.*

Activities:

1. Promote and publicize the Arthritis Foundation Washington/Alaska Chapter website as a credible source of information;
2. Increase the availability of easy-to-read messages developed and available through the national and local chapter of the Arthritis Foundation and other agencies;
3. Link the Arthritis Foundation website with the Department of Health website;
4. Develop and disseminate a resource guide on existing programs and sources of credible information on arthritis symptoms and treatment;
5. Promote and publicize the Arthritis Foundation's toll-free telephone number that connects callers to a University of Washington physician.

Objective 4: *Promote the value of early diagnosis and appropriate management to health care providers and people with arthritis.*

The findings from focus groups of people over 50 with symptoms of arthritis and from key informant interviews with health care providers in Washington indicate that providers and consumers are not communicating well with each other about arthritis.

Activities:

1. Identify subgroups of the target audience, including people with symptoms of arthritis and a full range of health care professionals⁹ to design appropriate messages that encourage early diagnosis and appropriate management;
2. Develop strategies to improve communication between health care providers and people with arthritis. An example suggested in one of the focus groups is a check list of questions and self-management options to discuss with a health care provider;
3. Develop or select key messages based on formative research results that promote the benefits of early diagnosis and appropriate management of arthritis;
4. Disseminate messages to diverse populations and age groups within Washington;
5. Evaluate effectiveness of the messages and interventions.

Arthritis Self-Help Course (ASHC) This instructional offering for people with arthritis consists of a six-week course (two hours per week), guided by two lay instructors, each of whom receives 18 hours of training. They follow a detailed protocol of instruction. The components of the ASHC are: 1) the effects and use of medications, 2) nutrition, 3) patient-physician communication, 4) types of arthritis, and 5) appropriate use of injured joints.

The interactive components of ASHC include designing individual physical activity, relaxation, and pain management programs. An evaluation of ASHC showed a 20 percent reduction in pain, and 40 percent reduction in physician visits, as well as increased self-efficacy.

The ASHC helped me learn how to manage the pain, find out there really are things I can do, and keep a better attitude. . .

— Joyce Gallagher
National Arthritis Action Plan

Objective 5: *Improve access to information on assistive technology that is feasible and relates to people with arthritis.*

Assistive technology maximizes functional opportunities for people with disabilities in all environments through the use of devices and services. For people with arthritis, operating controls and switches, gripping objects, and using tools are the most common problems. Some examples of assistive technology include adaptive garden tools, jar openers, light switches, walkers and modernized carts.

Activities:

1. Work with the Department of Social and Health Services Aging and Adult Services Administration, Area Agencies on Aging, independent living centers and the Arthritis Foundation to identify subgroups of people with arthritis who would benefit from assistive technology;
2. Educate people with arthritis about the benefits of assistive technology through the Arthritis Foundation website;
3. Promote Washington Assistive Technology Alliance's toll-free number and website as a source of up-to-date information on appropriate assistive technology.

Many people tend to accept arthritis as an inevitable part of aging. In the context of this perception, one focus group participant said, "It's like bifocals and gray hair; it comes with the territory."

Programs, policies and systems

Rationale: *To improve the quality of life for people with arthritis, efforts must go beyond data analysis and communication to modify public health, medical, and social service systems.*

There must be in place:

- A continuum of health services that includes secondary and tertiary prevention;
- A system of health services that bridges medical, voluntary, and public health agencies;
- Supportive policies to establish an environment conducive to preventive efforts;
- Community norms that promote prevention and improved quality of life;
- An advisory group to provide direction, partnerships and resources to carry out activities described in the plan.

Objective 1: *Identify strategies to modify health care systems to improve clinical services.*

Activities:

1. Work with the Department of Health Office of Community and Rural Health to analyze gaps in diagnostic and treatment services in rural counties in Washington;
2. Coordinate with efforts initiated by the Office of Community and Rural Health to reduce gaps in services;
3. Identify gaps in insurance coverage for medications and medical procedures for people with arthritis;
4. Develop strategies to reduce gaps in insurance coverage;

5. Work with HMOs to standardize screening, diagnosis, and continuum of care;
6. Explore the feasibility of working with the Center for Health Studies at Group Health Cooperative to use the Chronic Care Model to improve arthritis clinical care.

Objective 2: *Build arthritis capacity into the public health infrastructure.*

Activities:

1. Identify a program home for arthritis activities within the Department of Health;
2. Link with other chronic disease prevention activities as described in the Communication and Education section of the plan;
3. Identify additional partners and organizations willing to carry out or support activities described in the state plan;
4. Identify additional sources of funding and resources to carry out the activities described in the plan.

Objective 3: *Develop strategies to improve statewide access and culturally-appropriate services.*

Activities:

1. Identify gaps in the availability of physical activity programs, self-management courses, and nutrition services;
2. Increase the number of Arthritis Foundation education, exercise, and self-management programs, especially in under-served, rural areas of the state;
3. Increase the number of trained course educators;
4. Identify organizations such as local YMCAs and local health departments interested in sponsoring Arthritis Foundation programs;
5. Identify and reduce barriers such as access and cost for people with arthritis seeking services;
6. Promote the availability of services and programs to people with arthritis and health care providers.

Objective 4: *Use and disseminate evidence-based disease management programs and approaches.*

Activities:

1. Review other models of prevention for strategies that could be effective for people with arthritis;
2. Identify effective interventions by collaborating with the CDC Arthritis Program, the National Arthritis Foundation and other state health department arthritis programs;
3. Promote effective interventions through the Arthritis Foundation website, newsletters of professional organizations with chapters in Washington State and professional trainings and meetings;
4. Develop and put into place a system for regular dissemination of the most effective interventions.

Objective 5: *Further strengthen the partnership between the Arthritis Foundation Washington/Alaska Chapter and the Washington State Department of Health.*

Activities:

1. Collaborate with the Alaska Department of Health and other state arthritis programs by sharing resources, co-sponsoring trainings, and promoting program services;
2. Maintain and support the Washington Arthritis Advisory Group, whose role it is to identify the resources and partners needed to carry out the plan activities and to periodically evaluate and update the plan;
3. Continue to have Arthritis Foundation staff/board members serve on the Washington Arthritis Advisory Group;
4. Explore the feasibility of having a Department of Health staff serve as a liaison with the local Arthritis Foundation chapter's board of directors.

Appendices

A. References

1. Morbidity Mortality Weekly Review (1994). *Arthritis Prevalence and Activity Limitations – United States, 1990*. CDC, 1994; 43(24): 433-438.
2. U.S. Department of Health and Human Services. *Healthy People 2010: Focus Area 2, Arthritis, Osteoporosis and Chronic Back Conditions*. Washington, DC: January 2000.
3. The Behavior Risk Factor Surveillance Like Survey is a random, digit-dial telephone interview of households in Washington State. Only persons 18 and older are interviewed. The data is from 2000 interviews completed in the year 2000.
4. U.S. Department of Health and Human Services. *Healthy People 2010: Focus Area 2, Arthritis, Osteoporosis and Chronic Back Conditions*. Washington, DC: January 2000.
5. Ibid.
6. Centers for Disease Control and Prevention. *Targeting Arthritis: The Nation's Leading Cause of Disability*. Atlanta: 1999.
7. Arthritis Foundation, ASTHO, Centers for Disease Control and Prevention. *National Arthritis Action Plan*. Atlanta: 1999; 19.
8. Kruger JM, Helmick CG, Callahan LE, Haddix AC. *Cost-effectiveness of the Arthritis Self-Help Course*. Arch Intern Med. 1998; 158:1245–1249.
9. The definition of health care providers includes, but is not limited to: physicians, nurses, pharmacists, physical therapists, chiropractors, dieticians, social workers, acupuncturists, fitness professionals, massage therapists, herbalists, and holistic providers.

B. Healthy People 2010 Objectives

Healthy People 2010 outlines a comprehensive, nationwide health promotion and disease prevention agenda. It is designed to serve as a roadmap for improving the health of all people in the United States during the first decade of the 21st century.

Arthritis, osteoporosis, and chronic back conditions (chapter 2)

- 2-1. Increase the mean number of days without severe pain among adults who have chronic joint symptoms.
- 2-2. Reduce the proportion of adults with chronic joint symptoms who experience a limitation in activity due to arthritis.
- 2-3. Reduce the proportion of all adults with chronic joint symptoms who have difficulty in performing two or more personal care activities, thereby preserving independence.
- 2-4. (Developmental)* Increase the proportion of adults aged 18 years and older with arthritis who seek help in coping if they experience personal and emotional problems.
- 2-5. Increase the employment rate among adults with arthritis in the working-age population.
- 2-6. (Developmental) Eliminate racial disparities in the rate of total knee replacements.
- 2-7. (Developmental) Increase the proportion of adults who have seen a health care provider for their chronic joint symptoms.
- 2-8. (Developmental) Increase the proportion of persons with arthritis who have had effective, evidence-based arthritis education as an integral part of the management of their condition.

* Developmental objectives are qualitative or descriptive in nature and generally do not provide a numeric value as a target. Quantitative measurement systems are under development but not yet available for application. Qualitative objectives do however, provide a “vision” for a desired outcome or health status. Currently available surveillance systems and databases do not provide quantitative measures for these objectives. Inclusion of such objectives is expected to identify focus areas that are important and are also intended to motivate the development of national data systems through which they can be monitored.

Related objectives from other focus areas

Related objectives from other focus areas that relate to (or affect) persons with arthritis.

Access to quality health care

1-3. Counseling about health behaviors

Disability and secondary conditions

6-4. Social participation among adults with disabilities

6-5. Sufficient emotional support among adults with disabilities

6-8. Employment parity

Education and community-based programs

7-5. Worksite wellness promotion programs

7-6. Participation in employer-sponsored health promotion activities

7-10. Community health promotion programs

7-11. Older adult participation in community health promotion activities

Nutrition and overweight

19-1. Healthy weight in adults

19-2. Obesity in adults

19-16. Worksite promotion of nutrition education and weight management

19-17. Nutrition counseling for medical conditions

Occupational safety and health

20-2. Work-related injuries

20-3. Overexertion of repetitive motion

Physical activity and fitness

22-1. No leisure-time physical activity

22-2. Moderate physical activity

22-3. Vigorous physical activity

22-4. Muscular strength and endurance

22-5. Flexibility

Internet Resources

Arthritis Foundation www.arthritis.org

Centers for Disease Control & Prevention www.cdc.gov/nccdphp/arthritis

American College of Rheumatology www.rheumatology.org

Washington Assistive Technology Alliance www.wata.org

American Association of Acupuncture and Oriental Medicine www.aaom.org

American Academy of Medical Acupuncture www.medicalacupuncture.org